STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. 15,152

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Appeal of)

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INTRODUCTION

The petitioner appeals the decision by the Department of Social Welfare requiring the petitioner to enroll in a managed health care plan under Medicaid. The issue is whether the regulations mandate the petitioner being placed in a managed care plan.

FINDINGS OF FACT

In lieu of oral testimony the petitioner submitted the following written statement of her grievances against the Department.

A few days later, the petitioner informed the Board that the Department had sent her a notice (dated September 24, 1997) stating that unless she contacted them at once, she would be enrolled in a plan of the Department's choosing. The petitioner maintains that she should not be required to choose a plan unless and until the instant appeal is decided against her. She also alleges that the Department's earlier informational mailings about the managed care plans available to Medicaid recipients resembled "junk mail"; and she threw them away without reading them, and is, thus, uninformed at this time about the plans available to her.

ORDER

The Department's decision requiring the petitioner to enroll in a Medicaid managed health care plan is affirmed. The matter is remanded to the Department to provide the petitioner with all available information about the different plans that are offered and to allow the petitioner to choose the plan she wishes to enroll in.

REASONS

The Vermont legislature has specifically authorized the Commissioner of the Department of Social Welfare to "contract with a private organization to operate, under his (sic) control and supervision, parts of the medical assistance program." 33 V.S.A. § 1903(a).

Medicaid Manual § M103 provides as follows:

Covered services for eligible recipients are provided through fee-for-service and managed health care delivery systems. With the exception of the following groups, all Medicaid recipients are required to enroll in managed health care plans subject to plan availability and capacity. Recipients who are not eligible for managed health care plan enrollment are:

a) recipients who also have Medicare (Parts A and/or B):

b) home and community based waiver recipients;

c) recipients living in long-term care facilities, including ICF/MRs;

d) recipients who are receiving hospice care when they are found eligible for Medicaid;

e) children under age 21 enrolled in the high-tech home care program;

f) recipients who have private insurance that includes both hospital and physician services;

g) recipients residing in a geographic area where only one managed health care plan operates, unless they choose to be enrolled in that plan; Note: The standards the department uses to determine the geographic area that a managed health care plan serves are defined in the Welfare Procedures Manual at P-2443; these standards are in accordance with federal standards for access to care and the Vermont Health Resource Management Plan.

h) recipients who meet a spend-down who are not enrolled in a VHAP managed health care plan.

Exceptions from required enrollment may be made for individuals who would otherwise be enrolled in managed care for three months or less based on known changes, such as becoming Medicare-eligible.

The petitioner does not allege, nor does it appear from the record, that she falls into any of the above exceptions. Inasmuch as the Department's decision to require her to enroll in a managed care program is in accord with the applicable statute and regulations, the Board is bound by law to affirm that decision. 3 V.S.A. § 3091(d) and Fair Hearing Rule No. 17. However, given the fact that the petitioner filed this appeal during the managed care plan assignment period, she shall now be allowed to review the information available and to make her choice accordingly.(1)

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1. The petitioner's concerns about the manner in which the Department informed Medicaid recipients about the changeover to managed care, and her more general concerns about the lack of "communication" between the Department and the public, should be addressed directly to the Commissioner, as they are personnel and policy matters that do not directly affect the petitioner's receipt of benefits and are beyond the Board's authority to redress at this time. See 3 V.S.A. § 3091(a).